

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
TASIGNA (nilotinib)

Patient name:_____Medicaid or SS#_____
Physician Name:_____Contact person:_____
Phone#:_____Ext. and opt._____Fax#_____
Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES TO: 801-536-0477

CRITERIA:

- Minimum age requirement: 18 years old.
- Diagnosis of chronic myelogenous leukemia.
- Documented intolerance or resistance to therapy that includes Gleevec.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone call from physician's office or pharmacy.

02/17/2009